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EMPLOYEE BENEFITS

# Requirements for the Surprise Billing Under the No Surprises Act

July 2021

On July 1, 2021, the U.S. Departments of Health and Human Services (HHS), Labor and the Treasury, as well as the Office of Personnel Management, issued interim final rules for Requirements Related to Surprise Billing; Part I ("Rules"). These Rules implement portions of the No Surprises Act, which was contained in the COVID-19 relief bill signed into law at the end of 2020 (see our article here). The Rules are intended to protect individuals from surprise medical bills. The published version of the regulations is available here.

The agencies indicated that these regulations are part of a series of regulations (thus why they are referred to as "Part I") that will be issued implementing the No Surprises Act. Future regulations will address other provisions of the law, such as the transparency provisions. The agencies acknowledged that some of these regulations will not be published before the effective date of the various provisions of the law, which for most provisions is the first day of the plan year that begins on or after January 1, 2022. Until guidance is provided, group health plans are expected to comply with the statutory requirements using a reasonable, good faith interpretation of the law.

## The Issue Addressed by the Rules

### Surprise Billing and Balance Billing

Generally, when a covered individual uses an out-of-network facility or provider, the group health care plan will not cover the entire amount billed. Even if the individual uses a network facility, it is possible that one or more providers working at the facility are not participating in the plan's network, which can result in the individual being billed for the amount in excess of what the plan will pay.

This can result in a surprise medical bill from a health care provider when a covered person receives medical services from a provider or facility that, usually unknown to the individual, is a non-participating provider or facility with respect to the individual's coverage. Surprise billing can come from both emergency and non-emergency care.

Surprise billing is also referred to as "balance billing." As used in the Rule, balance billing refers to the practice of out-of-network providers billing patients for the difference between:

1. The provider's billed charges, and
2. The amount collected from the plan or issuer plus the amount collected from the patient in the form of cost-sharing (such as a co-payment, co-insurance or amounts paid toward a deductible).

The No Surprises Act and the Rules seek to eliminate surprise/balance billing in certain limited situations (discussed below) by imposing certain requirements on group health plans, insurance issuers and health care providers and facilities.

## Key Outcomes

The No Surprises Act, as implemented by the Rules:

- Prohibits surprise billing for emergency services. Regardless of where they are provided, emergency services must be treated as in-network without requirements for prior authorization.
- Prohibits high out-of-network cost-sharing for emergency and non-emergency services. Patient cost-sharing, such as co-insurance or a deductible, cannot be higher than if an in-network doctor provided such services, and any co-insurance or deductible must be based on in-network provider rates.
- Prohibits out-of-network charges for ancillary care (like an anesthesiologist or assistant surgeon) at an in-network facility in all circumstances.
- Prohibits other out-of-network charges without advance notice. Health care providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before that provider can bill at the higher out-of-network rate.

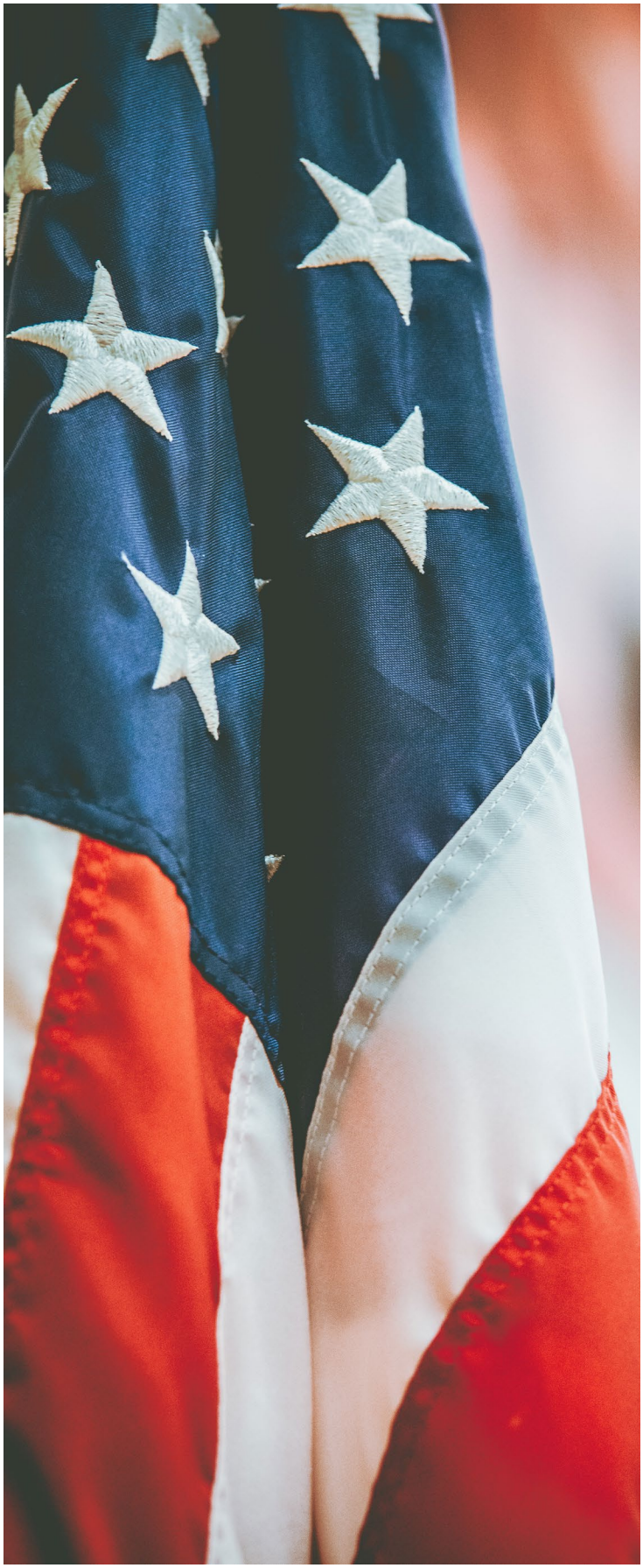
## Applicability of the Rules

The Rules apply to group health plans (including grandfathered plans) and insurance issuers issuing coverage in the group or individual markets. They also apply to providers, facilities, air ambulance services and the Federal Employees Health Benefits Act (FEHBA).

The following group health care plans are excepted from this rule:

- Excepted benefits (e.g., stand-alone dental and vision plans)
- Short-term, limited-duration insurance
- Health reimbursement arrangements or other account-based group health plans
- Retiree-only health plans

The focus of this article is the application of the Rules to group health plans. However, we have included some basic information regarding the Rules that apply to providers and facilities, especially in cases in which they indirectly impact group health plans and their participants.



# Surprise Billing Requirements Applicable to Group Health Plans and Insurance Issuers

## Notice Requirements

The No Surprises Act includes a provision that requires group health plans and insurance issuers to make publicly available certain information regarding the Rules. They are required to post this information on a public website of the plan or issuer and include it on each explanation of benefits for an item or service with respect to which the surprise billing requirements apply. This notice requirement is effective for plan years beginning on or after January 1, 2022.

In conjunction with the release of the Rules, the agencies published a model notice that group health plans may (but are not required) to use to comply with that notice obligation. The model notice, with instructions, is available here.

The notice requirements are not specifically addressed in the Rules. According to the preamble, the agencies may issue regulations implementing the notice requirements in the future. Until then, group health plans are expected to comply with the statutory requirements using a reasonable, good-faith interpretation of the law.

## Calculating Payments to Non-Participating Providers and Facilities

Under the Rules, determination of the amount the plan must pay to out-of-network or non-participating facilities and/or providers is based on: (1) an amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act; (2) if there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law; (3) if there is no such applicable All-Payer Model Agreement or specified state law, an amount agreed upon by the plan or issuer and the provider or facility; or (4) if none of those three conditions apply, an amount determined by an independent dispute resolution (IDR) entity. Regulations regarding the IDR process are forthcoming.

This “out-of-network rate” is not necessarily the same as the “recognized amount” used for purposes of applying the plan’s cost-sharing requirements. Accordingly, the preamble recognizes that in some cases, the plan will pay the facility and/or provider even though the participant has not satisfied the plan’s deductible (based on the “recognized amount”). Section 223 of the Internal Revenue Code was amended to protect a plan’s status as a qualified HDHP in these cases.

## Emergency Services Coverage Requirements

For emergency services*, if a group health plan provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department**, the plan must cover emergency services:

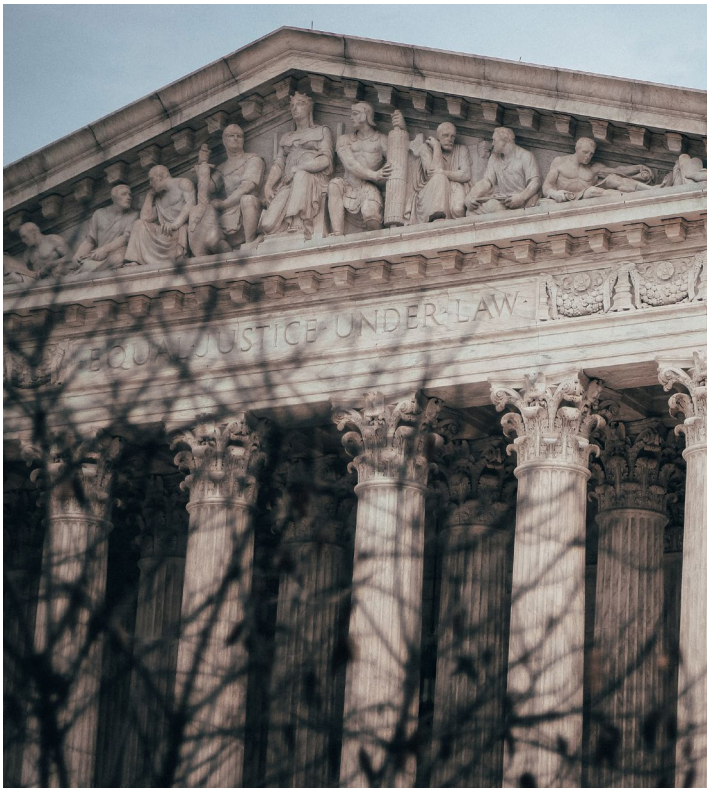
1. Without prior authorization (even if out-of-network).
2. Without regard to whether the health care provider furnishing the emergency services is a participating provider or a participating emergency facility.
3. Without limiting what constitutes an emergency medical condition solely on the basis of diagnosis codes. According to the preamble, this requirement puts an end to the practice of "deny[ing] coverage of certain services provided in the emergency department of a hospital by determining whether an episode of care involves an emergency medical condition based solely on final diagnosis codes . . .." In general, whether an emergency medical condition exists is determined using a prudent layperson standard.
4. Without regard to any other term or condition of the coverage except the following plan provisions: (i) the exclusion or coordination of benefits provisions (to the extent not inconsistent with benefits for an emergency medical condition); (ii) the affiliation or waiting period requirements; and (iii) the applicable cost-sharing requirements.

Furthermore, if the emergency services are provided by a non-participating provider or a non-participating emergency facility:

1. The plan must cover emergency services without imposing any administrative requirement or limitation on coverage that is more restrictive than those applicable to participating providers and emergency facilities.
2. The plan must cover emergency services without imposing cost-sharing requirements that are greater than the requirements that would apply if the services were provided by a participating provider or emergency facility.
3. The plan must calculate the cost-sharing requirement as if the total amount that would have been charged for the services by such participating provider or participating emergency facility were equal to the "recognized amount" for such services. The Rules indicate the "recognized amount" is: (1) an amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act; (2) if there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law; or (3) if there is no such applicable All-Payer Model Agreement or specified state law, the lesser of the billed charge or the plan's or issuer's median contracted rate, referred to as the "qualifying payment amount" (QPA). The Rules contain detailed requirements regarding the determination of the QPA.
4. The plan must count any cost-sharing payments made by the participant or beneficiary with respect to the emergency services toward any in-network deductible or in-network out-of-pocket maximums (including the annual limitation on cost-sharing under the Affordable Care Act) in the same manner as if the cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility.
5. Not later than 30 calendar days after the bill for the services is transmitted by the provider or facility or, if later, after the plan receives the information necessary to decide a claim, the plan must determine whether the services are covered under the plan and, if so, send an initial payment or a notice of denial of payment. In cases in which the "recognized amount" is determined by a specified state law or All-Payer Model Agreement, the timeframe specified by the state law or All-Payer Model Agreement will apply instead. The preamble to the Rules indicates the initial payment will be the amount the plan or issuer reasonably intends to be the full payment.
6. When the QPA serves as the recognized amount, the plan or issuer must make certain disclosures with each initial payment or notice of denial of payment and must provide additional information upon request of the provider or facility.
7. The plan must make a total plan payment directly to the non-participating provider or non-participating facility that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount made as described above within certain timeframes.

** Emergency services are defined broadly and they include pre-stabilization services provided after the patient has been admitted to the hospital and certain post-stabilization services (regardless of the department in which they are provided) provided as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the other emergency services are furnished unless the notice and consent conditions have been met.*

*** Depending on state law, independent freestanding emergency departments currently would include urgent care centers that are permitted by state law to provide emergency services. However, the HHS has requested comments on this issue.*




## Non-Emergency Services Coverage Requirements

For non-emergency services provided by non-participating providers with respect to a visit*** to a participating facility, unless the provider satisfies certain notice and consent requirements discussed below, the plan:

1. Must not impose a cost-sharing requirement for the items and services that is greater than the cost-sharing requirement that would apply if a participating provider had furnished the items or services.
2. Must calculate the cost-sharing requirements as if the total amount that would have been charged for the items and services by such participating provider were equal to the "recognized amount" for the items and services. "Recognized amount" is defined the same as it is for purposes of emergency services at non-participating providers/facilities.
3. Must count any cost-sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums (including the annual limitation on cost-sharing under the Affordable Care Act) in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a participating provider.
4. Not later than 30 calendar days after the bill for the services is transmitted by the provider or facility or, if later, after the plan receives the information necessary to decide a claim, must determine whether the services are covered under the plan and, if so, send an initial payment or a notice of denial of payment. In cases in which the "recognized amount" is determined by a specified state law or All-Payer Model Agreement, the timeframe specified by the state law or All-Payer Model Agreement will apply instead. The preamble to the Rules indicates the initial payment will be the amount the plan or issuer reasonably intends to be the full payment.
5. When the QPA serves as the recognized amount, the plan or issuer must make certain disclosures with each initial payment, or notice of denial of payment and must provide additional information upon request of the provider or facility.
6. Must make a total plan payment directly to the non-participating provider or non-participating facility that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount made as described above within certain timeframes. The out-of-network rate is determined as described above with respect to emergency services.

## Air Ambulance Services Coverage Requirements

If a group health plan provides or covers any benefits for air ambulance services provided by a non-participating provider in accordance with the following requirements:

1. The cost-sharing requirements with respect to the services must be the same requirements that would apply if the services were provided by a participating provider of air ambulance services.
2. The cost-sharing requirement must be calculated as if the total amount that would have been charged for the services by a participating provider of air ambulance services were equal to the lesser of the QPA or the billed amount for the services.
3. The cost-sharing amounts must be counted towards any in-network deductible and in-network out-of-pocket maximums (including the annual limitation on cost-sharing under the Affordable Care Act) in the same manner as if the cost-sharing payments were made with respect to services furnished by a participating provider of air ambulance services.

**** A visit is defined to include, in addition to items and services furnished by a provider at the facility, equipment and devices, telemedicine services, imaging services, laboratory services and preoperative and postoperative services, regardless of whether the provider furnishing such items or services is at the facility.*

4. Not later than 30 calendar days after the bill for the services is transmitted by the provider or facility or, if later, after the plan receives the information necessary to decide a claim, the plan must determine whether the services are covered under the plan and, if so, send an initial payment or a notice of denial of payment. The preamble to the Rules indicates the initial payment will be the amount the plan or issuer reasonably intends to be the full payment.

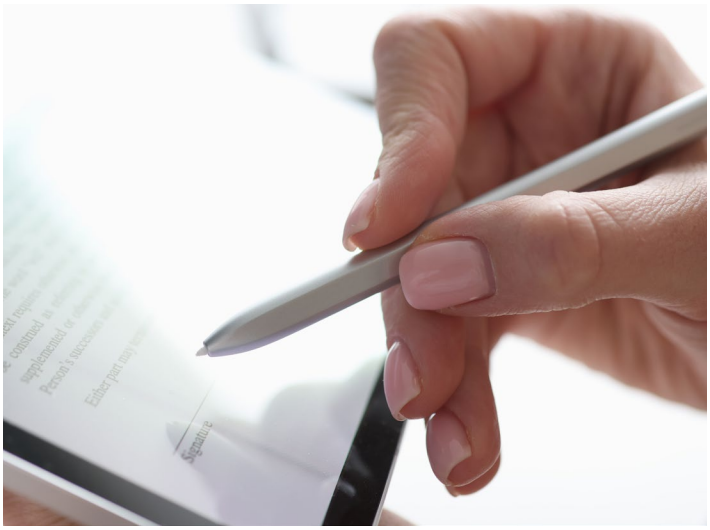
5. When the QPA serves as the recognized amount, the plan or issuer must make certain disclosures with each initial payment or notice of denial of payment and must provide additional information upon request of the provider or facility.

6. The plan must make a total plan payment directly to the non-participating provider or non-participating facility that is equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services, less any initial payment amount made as described above within certain timeframes. The out-of-network rate is determined as described above with respect to emergency services.

## Surprise Billing Requirements Applicable to Health Care Providers/ Facilities

### Prohibition on Balance Billing and the Notice and Consent Exception

The No Surprises Act and the Rules generally prohibit providers and facilities from balance billing for services subject to the Rules (e.g., emergency services provided by non-participating providers and facilities, non-emergency services provided by a non-participating provider at a participating facility and air ambulance services provided by a non-participating provider). However, the prohibition on balance billing (and the rules regarding cost-sharing described above) do not apply to certain services (i.e., post-stabilization services and certain non-emergency services performed by non-participating providers at participating facilities) if the provider or facility provides notice to the participant and obtains the individual's consent to waive the balance billing protections.



The Rules describe specific requirements regarding this notice and consent exception. Furthermore, because a group health plan's obligations are affected when a provider or facility properly obtains a participant's consent to waive the protections, the Rules require providers and facilities to notify group health plans and issuers when consent is obtained.

### Notice Requirements

Similar to the requirement that applies to group health plans and issuers, the Rules also implement the statutory requirement that certain health care providers and facilities make publicly available, post on a public website and provide a one-page notice to individuals regarding: (1) the requirements and prohibitions applicable to the provider or facility under the surprise billing provisions; (2) any applicable state balance billing requirements; and (3) how to contact appropriate state and federal agencies if the individual believes the provider or facility has violated the requirements described in the notice.

## Effective Dates of Surprise Billing Requirements

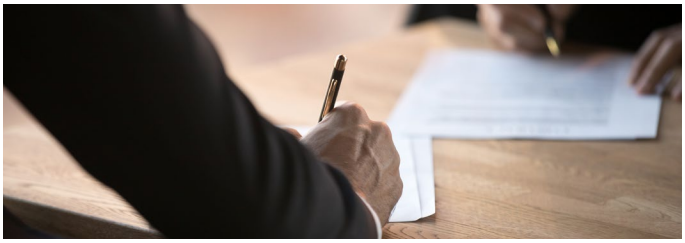
- The regulations are generally applicable for plan years (in the individual market, "policy years") beginning on or after January 1, 2022.
- The HHS-only regulations that apply to health care providers, facilities and providers of air ambulance services are applicable beginning on January 1, 2022.

## Additional Group Health Plan Requirements Addressed by the Rules *(Not Related to Surprise Billing)*

### Choice of Health Care Professional Requirements

The No Surprises Act extends the applicability of the Affordable Car Act's (ACA's) patient protections for choice of health care professionals to grandfathered health plans. Beginning with the first plan year beginning on or after January 1, 2022, all group health plans (both grandfathered and non-grandfathered) must comply with this ACA requirement.

The Rules restate the regulations issued under the ACA regarding choice of health care professionals. The Rules provide that if a group health plan requires the designation of a primary care provider, the plan must allow each participant or beneficiary under the plan to designate any available primary care provider. Notice of this requirement must be included whenever a summary plan description or other similar description of benefits is provided. Also, the plan may not require authorization or referral for female participants/beneficiaries who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology.



## Action Items for Sponsors of Group Health Plans

For fully insured plans, the responsibility for complying with the No Surprises Act and these Rules will fall primarily on the insurance carrier. Nevertheless, plan sponsors should obtain confirmation from their carriers that they are taking responsibility for compliance because some requirements apply jointly to the group health plan and the issuer of the group health insurance policy.

For self-insured plans, although the plan sponsor's plan is directly responsible for complying with the requirements, as a practical matter, the plan's third-party administrator (TPA) will need to be responsible for most of the actions needed to comply. In some limited cases (e.g., complying with the health plan notice requirements), plan sponsors may need to take action. Plan sponsors should review their service agreements and discuss with their TPA's each party's respective responsibilities for complying with the new requirements.

Sponsors of self-insured plans will also want to consider how the surprise billing requirements might impact claims expenses and provider contracting in the 2022 plan year and beyond. Presumably, the new surprise billing requirements will result in an increase in plan expenses because participant cost-sharing for services at these out-of-network providers/facilities will, under many plans, be lower in 2022 and the payments made to the providers/facilities will likely be higher.

Furthermore, some providers and facilities that are subject to the surprise billing requirements might choose to cease contracting with plans and become non-participating providers/facilities. This remains to be seen and will depend on how providers view the Rules' provision regarding "out-of-network rate" and the forthcoming regulations regarding the IDR process. However, there is at least a possibility the Rules will have an impact on networks and contracts with providers.

Finally, sponsors of self-insured plans should work with their TPAs and legal counsel to ensure that any revisions needed to plan documents and Summary Plan Descriptions as a result of the Rules are made in a timely manner. Examples of potential amendments include:

- Revising definitions of key terms (e.g., emergency services) to match the definitions contained in the Rules.
- Amending the plan's cost-sharing requirements for out-of-network emergency services, services provided by out-of-network providers during a visit to an in-network facility and out-of-network air ambulance services.
- For grandfathered plans that impose prior authorization requirements for out-of-network emergency services or exclude coverage for out-of-network emergency services, amending the plan to eliminate prior authorization requirement or eliminate exclusion.
- For grandfathered plans that required a designation of a primary care provider, revising the rules regarding such designations to allow members to designate any available primary care provider.

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